HMG Holston Medical Group 2323 N. John B. Dennis Hwy. • Kingsport, TN 37660 • 423-857-2000 Fax 423-857-2050

Scott R. Fowler, J.D., M.D., President & CEO • Samuel D. Breeding, M.D., Chief Medical Officer

November 22, 2016

John J. Dreyzehner, MD, MPH, FACOEM
Commissioner, Tennessee Department of Health
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

RE: Comments regarding Application for Certificate of Public Advantage Submitted by Mountain States Health Alliance and Wellmont Health System

Commissioner:

Thank you for the opportunity to provide comments regarding the Application by Mountain States Health Alliance ("MSHA") and Wellmont Health System ("WHS") for a Certificate of Public Advantage ("COPA") being considered by the Department of Health (the "Department").

Holston Medical Group, P.C. ("HMG") is one of the largest multi-specialty provider groups within the Southeast United States, and the state's first multi-specialty NCQA-Level III patient-centered medical home. Our "Family of Care" consists of more than 800 employees, including more than 150 physicians and mid-level providers. In addition to being one of the region's most advanced primary care group practices (family/internal medicine, pediatrics/adolescent medicine), our group also includes multi-specialty care, on-site diagnostic and laboratory services, a sleep center, and outpatient rehabilitation services.

HMG has extensive relationships with both MSHA and WHS facilities through its patient population using their services as well as the through providing medical director, call coverage and other services to various hospital facilities. HMG respects that the merger of MSHA and WHS has the potential for significant community benefits. While the Application focuses extensively on these benefits it also assumes the continuation and expansion of existing governance, financial, and operational structures with a weak accountability mechanism. HMG is concerned about the continued reliance on traditional hospital care delivery structures and governance
.e the application leaves in place.

However, HMG agrees that, if properly regulated, the New Health System could benefit the Geographic Service Area.

Regulatory Oversight

The State Action Immunity Doctrine requires that the state ***actively*** supervise (regulate) state approved anticompetitive mergers. The Tennessee legislature has acknowledged the importance of regulatory oversight:

> It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part ***and to actively supervise that regulation to the fullest extent required by law***, in order to promote cooperation and coordination among hospitals in the provision of health services and to provide state action immunity from federal and state antitrust law to the

> fullest extent possible to those hospitals issued a certificate of public advantage under this section.

The Hospital Cooperation Act of 1993, T.C.A.§ 68-11-1303(a) (emphasis added).

The Applicants have proposed the creation of a monolithic, region-wide, monopolistic structure. It will control the majority of health care real estate and provide services in many sectors of the health care delivery system in the Geographic Service Area. Every decision made by the New Health System will not only impact the delivery of services to patients but will impact the ways in which independent providers operate and deliver services, as well as how others that touch the health care industry manage their businesses such as banks, real estate companies, suppliers, and consultants. Because of this inter-dependent complexity, the regulatory authority of the State of Tennessee will result in direct regulation of the New Health System but indirect regulation of the entire health care industry in the Geographic Service Area – whether it is an independent medical provider, or a business involved in or touching the delivery of health care.

HMG, therefore, advocates for a robust regulatory authority – locally based, collaboratively structured, with authority to orchestrate dialogue within the Geographic Service Area and make enforceable decisions. This is not a "check the box" environment. Active supervision is continual and integral involvement in the process of carrying out the promises of the New Health System and verifying compliance with the mandates of the Index to be developed by the Department is the only avenue for guaranteeing the benefits of the merger of MSHA and Wellmont are realized and outweigh the risks associated with the anticompetitive merger.

Quality and Cost

The health care industry is undergoing monumental shifts in both delivery and payment for services. Greater focus is placed on higher quality at reduced costs. HMG agrees with the Federal Trade Commission ("FTC"):

> The elimination of competition between Mountain States and Wellmont will significantly diminish the hospitals' incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival. Importantly, a reduction in quality of care can have an adverse effect on patient outcomes such as mortality, readmissions, and length of stay. Reduced availability of services may result in decreased patient access, increased travel time to receive services, increased emergency room wait times, and other negative consequences. Indeed, the empirical economic evidence indicates that increased competition is associated with better quality.[1]

Likewise, cost continues to be a significant issue in health care. The FTC highlighted a number of concerns regarding the Applicant's proposed price controls including potential ambiguities, appropriate metrics, the "locking in" of inflated charges, and the limited application of the commitment.[2]

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[1] Federal Trade Commission Staff Submission to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System; September 30, 2016; Page 23.

[2] Federal Trade Commission Staff Submission, Pages 54 – 56.

These discussions focus on the costs to patients, employers, and insurers. However, the impact of poor quality and higher costs also limit the ability of emerging reimbursement models to flourish in the region. Value-based health care delivery methods base provider reimbursement on both the quality and costs of ALL the services delivered to patients including inpatient services, outpatient services, and prescription drugs. In our current environment, patients and providers participating in value-based contracts can self-select higher quality, lower cost providers. Without this ability, patients and providers in our region will be less able to participate in health care innovation models because they cannot effect improvement in these metrics or spur innovation in quality, services or costs.

Continual monitoring and improvement in both cost and quality in the New Health System is a fundamental issue that must be virtually guaranteed in order to reap some of the most important benefits of the proposed merger.

Inflated Hospital Costs

Hospital systems have enjoyed an inflated reimbursement model. This is due largely to the methods used by CMS to fund innovation and reimburse care but is also based on the size and importance of inpatient services to both CMS and commercial payors. CMS has begun to shrink this gap, however, it remains significant and any downward pressure on CMS rates may not automatically translate to reduced reimbursements under commercial payor agreements.

These inflated hospital costs distort the market. They reduce competition by pushing independent providers of medical, surgical, and outpatient services of all types into hospital-based arrangements. This is most dramatically seen in the outpatient context, especially where a Certificate of Need is required to provide the services. Because of the higher-hospital based reimbursement model and the hospital's ability to negotiate higher rates, the New Health System will continue to have access to greater capital to compete in this market. HMG believes that the delta between the hospital-based reimbursement model and the independent reimbursement models should serve as one of the benchmarks for success of the merger.

Size Matters

Throughout the evaluation of the Application, there have been numerous calls for strict limits on the size of certain service lines, including limits on physician employment. While there must exist a number of permutations for rural areas, highly specialized physicians and other exceptions, a limit on physician employment does act as a fairly direct control on a very large and complex problem and fear.

However, it's not just about an overall limit or even a limit in any particular specialty. The problem becomes acute when comparing the sheer number of providers in a single New Health System provider practice when compared to the largest group of similarly situated providers in an independent group.

Based on Exhibit 6.1E to the Applicant's Supplement to Responses to Questions dated July 25, 2016, once merged the New Health System will only employ 25.3% of the 2,913 members of the physician community:

	Independent	Wellmont	Mountain States	Mountain States Affiliated	New Health System
	74.7%	11.7%	10.3%	3.4%	25.3%
2,913	2,176	340	300	99	737

While this does not, on its face, appear to be alarming a different picture emerges when you consider that the 737 providers employed by the New Health System are essentially in one medical group. Exhibit 3B to the Supplemental Response breaks out the numbers of physicians in independent physician groups. There are only three in the "100 or more" category and one of those is "Appalachian Emergency Physicians" – a group wholly dependent on the New Health System for its business:

Group Size	Number of Groups
100 or more	3
50-99	2
26-49	5
10-25	17
5-9	52
1-4	416

Note: This chart does not include 185 physicians with unknown affiliation

Even if any imposed pricing controls are effective, the sheer size of such a physician group when compared to the rest of the physician community supplies the New Health System with cost efficiencies, internal referral patterns, marketing power and other benefits that the remainder of the physician community could never match.

In addition, this situation encourages a physician-employment model that undermines the physician-patient relationship by imposing non-physician corporate governance over the responsibilities of highly trained professionals. HMG believes in the corporate practice of medicine doctrine and that there are too many exceptions to its strictures. The merger of MSHA and WHS will inflict irreparable damage to independent professionalism in exchange for corporate efficiencies.

OnePartner

HMG applauds the willingness of the Applicants to support regional health information exchange. The region currently has a health information exchange, OnePartner, LLC, to which a very large majority of independent physicians subscribe. In addition, Mountain States and WHS participate with OnePartner though some gaps exist in the data being contributed.

HMG sees robust and complete participation by the New Health System in OnePartner as a lynch-pin in supporting the continued existence and success of independent physicians and other outpatient service providers. As discussed above, the movement towards value-based models of care require seamless coordination of care across all providers. If the New Health System's common IT platform does not support robust bi-directional data exchange, it will promote barriers to data sharing and provider workflow.

OnePartner currently provides near real-time access to patient data within the provider's current workflow with no need to log into portals or other means to review data. If providers are required to log into a separate portal for this data, a barrier to data access has been erected. Such a barrier could also have the effect of encouraging providers to become employed by the New Health System or accept installation of the New Health System's hospital-centric IT platform in their own office to timely access patient data.

OnePartner offers an EMR agnostic solution for all providers that promotes exchange as well as a means and method to coordinate population health and value-based contracting models. While HMG applauds the New Health System's promises to promote population health and value-based models of care, these efforts cannot be confined inside the New Health System's administrative structures. By definition, these efforts must be community wide using systems that make this data and information seamlessly available to all providers of care.

HMG believes that the Index developed for the COPA must include measures to track the following subjects related to the Applicant's participation in health information exchange:

- How well the Applicants leverage existing investments in health information exchange;
- How well the Applicants encourage and support patient and provider connectivity to the health information exchange;
- The movement of the Applicant's patient communication into the health information exchange thus providing the patient community one-stop access to all providers, including the Applicants and independent providers;
- A definition of the level of data to be provided by the Applicants to the health information exchange that ensures that sufficient data is available to independent providers not just for patient care but enables independent practitioners the ability to meet quality and value based requirements. This definition should insure that independent practitioners have access to substantially the same level of data available to practitioners employed by the New Health System.
- The actual value of dollars spent by the Applicants for health information exchange that benefit both employed and independent providers of medical services.

Closing Thoughts

While HMG respects the view that the merger of MSHA and WHS has the potential to be more beneficial than their continued existence as separate and competing entities, the ability to achieve this promise is subject to substantial risk. This letter has addressed only a tiny fraction of the issues and concerns regarding the effects of the merger. Even if each and every issue could be resolved in a way that protects the health of the community and the vibrancy of the independent health care delivery sectors it is imperative that a regulatory authority capable of overseeing the complexity of the new health care reality in the Geographic Service Area is established.

The Hospital Cooperation Act of 1993, Section 68-11-1303(1) provides that:

> The department shall issue a certificate of public advantage for a cooperative agreement, if it determines that the applicants have demonstrated ***by clear and convincing evidence*** that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.

HMG believes the Application as currently proposed by the New Health System promises many benefits to our community. However, these promises and the Application's proposed regulatory framework for analyzing its success provides little surety that the benefits will be realized. HMG believes that any COPA issued by the Department of Health to the Applicants must result in a structure that provides clearly defined results with regulatory teeth sufficient to guaranty they are successfully achieved.

Scott R. Fowler, J.D., M.D.
President / CEO

Randall E. Sermons
General Counsel

cc:
Alan Levine
Bart Hove

Senator Rusty Crowe
Senator-elect Jon Lundberg
Senator Frank S. Niceley
Senator Steve Southerland

Representative-elect John Crawford
Representative David Hawk
Representative Matthew Hill
Representative Timothy Hill
Representative John B. Holsclaw, Jr.
Representative Bud Hulsey
Representative James (Micah) Van Huss